PUBLIC EMPLOYEES HEALTH BENEFIT ACT (EXCERPT)
Act 106 of 2007

***** *124.85.amended THIS AMENDED SECTION IS EFFECTIVE OCTOBER 1, 2011* *****

124.85.amended Public employer with 100 or more employees; claims utilization and cost information; compilation; "relevant period" defined; disclosure; availability; protected health information not included; date of compilation.

Sec. 15. (1) Notwithstanding subsection (2), a public employer that has 100 or more employees in a medical benefit plan shall be provided with claims utilization and cost information as provided in subsection (3).

(2) A public employer that is in an arrangement with 1 or more other public employers, and together have 100 or more employees in a medical benefit plan or have signed a letter of intent to enter together 100 or more public employees into a medical benefit plan, shall be provided with claims utilization and cost information as provided in subsection (3) that is aggregated for all the public employees together of those public employers, and, except as otherwise permitted under subsection (1), shall not be separated out for any of those public employers.

(3) All medical benefit plans in this state shall compile, and shall make available electronically as provided in subsections (1) and (2), complete and accurate claims utilization and cost information for the medical benefit plan in the aggregate and for each public employer as follows:

(a) A census of all covered employees, including all of the following:

(*i*) Year of birth.

(*ii*) Gender.

(*iii*) Zip code.

(*iv*) The contract coverage type for the employee, such as single, dependent, or family, and number of individuals covered by contract.

(b) Claims data for the employee group covered by the medical benefit plan, including at least all of the following:

(*i*) For a plan that provides health benefits, information concerning hospital and medical claims under the plan, presented in a manner that clearly shows all of the following for each of the 3 most recent experience years:

(A) Number and total expenditures for hospital claims.

(B) Number and total expenditures for medical claims.

(C) Number of hospital claims exceeding $50,000.00.

(D) Number of medical claims exceeding $50,000.00.

(E) Total expenditures for claims exceeding $50,000.00.

(*ii*) For a plan that provides prescription drug benefits, information concerning prescription drugs claims under the plan, presented in a manner that clearly shows all of the following:

(A) Amount charged and amount paid for prescription drugs claims for each of the 3 most recent experience years.

(B) Total amount charged and amount paid for brand prescription drugs claims for each of the 3 most recent experience years.

(C) Total amount charged and amount paid for generic prescription drugs claims for each of the 3 most recent experience years.

(D) The 50 most frequently prescribed brand prescription drugs for which claims were made for the most recent experience period.

(E) The 50 most frequently prescribed generic prescription drugs for which claims were made for the most recent experience period.

(*iii*) For a plan that provides dental benefits, information concerning dental claims and total expenditures for these claims under the plan, presented in a manner that clearly shows at least all of the following for each of the 3 most recent experience years:

(A) Number of claims submitted and total charged.

(B) Number of and total expenditures for claims paid.

(C) Total expenditures for claims submitted to network providers.

(*iv*) For a plan that provides optical benefits, information concerning optical claims and total expenditures for these claims under the plan, presented in a manner that clearly shows at least all of the following for each of the 3 most recent experience years:

(A) Number of claims submitted and total charged.

(B) Number of and total expenditures for claims paid.

(C) Total expenditures for claims submitted to network providers.

(c) Fees and administrative expenses for the most recent experience year, reported separately for health, dental, and optical plans, and presented in a manner that clearly shows at least all of the following:

(*i*) The dollar amounts paid for specific and aggregate stop-loss insurance.

(*ii*) The dollar amount of administrative expenses incurred or paid, reported separately for medical, pharmacy, dental, and vision.

(*iii*) The total dollar amount of retentions and other expenses.

(*iv*) The dollar amount for all service fees paid.

(*v*) The dollar amount of any fees or commissions paid to agents, consultants, third party administrators, or brokers by the medical benefit plan or by any public employer or carrier participating in or providing services to the medical benefit plan, reported separately for medical, pharmacy, stop-loss, dental, and vision.

(*vi*) Other information as may be required by the commissioner.

(d) For health, dental, and optical plans, a benefit summary for the current year's plan and, if benefits have changed during any of the 3 most recent experience years, a brief benefit summary for each of those experience years for which the benefits were different.

(4) Except as otherwise provided in subsection (3), claims utilization and cost information required to be compiled under this section shall be compiled on an annual basis and shall cover a relevant period. For purposes of this subsection, the term "relevant period" means the 36-month period ending no more than 120 days prior to the effective date or renewal date of the medical benefit plan under consideration. However, if the medical benefit plan has been in effect for a period of less than 36 months, the relevant period shall be that shorter period.

(5) A public employer or combination of public employers shall disclose the claims utilization and cost information required to be provided under subsections (1) and (2) to any carrier or administrator it solicits to provide benefits or administrative services for its medical benefit plan, and to the employee representative of employees covered under the medical benefit plan, and upon request to any carrier or administrator who requests the opportunity to submit a proposal to provide benefits or administrative services for the medical benefit plan at the time of the request for bids. The public employer shall make the claims utilization and cost information required under this section available at cost and within a reasonable period of time.

(6) The claims utilization and cost information required under this section shall include only de-identified health information as permitted under the health insurance portability and accountability act of 1996, Public Law 104-191, or regulations promulgated under that act, 45 CFR parts 160 and 164, and shall not include any protected health information as defined in the health insurance portability and accountability act of 1996, Public Law 104-191, or regulations promulgated under that act, 45 CFR parts 160 and 164.

(7) All claims utilization and cost information described in this section is required to be compiled beginning 60 days after the effective date of this act. However, claims utilization and cost information already being compiled on the effective date of this act is subject to this section on the effective date of this act.

History: 2007, Act 106, Imd. Eff. Oct. 1, 2007;—Am. 2011, Act 93, Eff. Oct. 1, 2011.